Gabrielle Carey, Ph.D., LMFT DATE:_____

FAMILY FORM

Partner 1 Name:_____

Partner 2 Name:_____

Address_____City_____Zip_____

Home Phone:_____ E-Mail:_____

Who referred you to us?_____

Partner 1 Date of Birth:_____Age:_____SS #:_____

Occupation_____ Employer_____

Work Address_____Zip_____

W. Phone_____ Cell/Pager:_____ E-Mail:_____

Partner 2 Date of Birth:_____Age:_____SS #:_____

Occupation_____ Employer_____

Work Address_____Zip_____

W. Phone_____ Cell/Pager:_____ E-Mail:_____

Children's Names	Age	Sex	Birthdate	SSN	Living at home Yes	No

Are there any other persons living in your household? Yes_____ No_____ If yes, please give their name/s and their relationship to your family.

CURRENT LIVING SITUATION

Married_____ Separated_____ Widowed_____ Engaged_____ Co-Habitating_____

How long have you been married, etc.?_____

Have you been married before? If so, for how long were you married ?
Partner 1: Yes_____/_____ No____ Partner 2: Yes_____/_____ No____

Are your parents living? If yes, please give their names, address(es), and telephone number(s).

1. Mother: Yes_____ No_____
   Father: Yes_____ No_____
2. Mother: Yes_____ No_____
   Father: Yes_____ No_____

BASIC HEALTH AND COUNSELING HISTORY

Partner 1: Good____ Fair____ Poor____ Date of last Physical Exam?_____

Name of Physician?_____ Phone_____

Are you taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes,what? _____

_____

_____

Have you ever been hospitalized? Yes_____ No_____ If so, for what?_____

_____

Do you drink alcohol? Yes____ No____If yes, amount? _____

Do you use any illegal drugs? Yes____ No____ If yes, what?_____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes____ No____ If yes, what?_____

_____

Have you had counseling in the past? Yes____ No____. If so, From:_____To:_____

With whom?_____ For what?_____

_____

BASIC HEALTH AND COUNSELING HISTORY (cont.)

Partner 2: Good____ Fair____ Poor____ Date of last Physical Exam?_____

Name of Physician?_____ Phone_____

Are you taking any prescription medication, over-the-counter medications, allergy medications, herbs, etc.? Yes_____ No_____ If yes,what? _____

_____

_____

Have you ever been hospitalized? Yes_____ No_____ If so, for what?_____

_____

Do you drink alcohol? Yes____ No____If yes, amount? _____

Do you use any illegal drugs? Yes____ No____ If yes, what?_____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes____ No____ If yes, what?_____

Have you had counseling in the past? Yes____ No____. If so, From:_____To:_____

With whom?_____ For what?_____

Children:

Have any of your children ever see a counselor before? Yes____ No____ Child_____

If yes, From_____ To_____ With whom?_____

For what?_____

Do any of your children have any physical, emotional, or mental condition now or in the past that I need to be aware of? Yes_____ No_____ If yes, what?_____

Do any of your children have any current social, intellectual, or academic problems?

Yes_____No_____ If yes, what?_____

Were there any significant prenatal or perinatal events during the pregnancy/birth of any of your children? Yes_____ No_____ If yes, what?_____

What medications or substances do your children use, if any? Yes_____ No_____

If yes, what?_____

Have any of your children been hospitalized? Yes_____ No_____

If yes, for what?_____

What is the name of the children's physician? _____

REASON(S) FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

What would you like to see happen as a result of counseling?

POLICY

A counseling session is normally 45-50 minutes. It is customary to pay your therapist after each session. A 24-hour cancellation OR rescheduling notice is required; otherwise the usual **full fee** will be charged. Emergencies will be handled on a case to case basis.

The therapist will maintain strict confidentiality. However, I understand that suicidal threats, homicidal threats, and child or elder abuse will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

I have signed the release of information form for my insurance company (if applicable), and I have been given the information form regarding privacy and confidentiality as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I understand that I have the right to refuse treatment at any time.

Signature of Partner 1:_____

Signature of Partner 2:_____

Signature of Psychotherapist:_____